

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02590		02555	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>11 months</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens Sanitarium</u>		d. STREET ADDRESS <u>5302 Locust Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Sophie C. Raguse</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH <u>February 22 1966</u>		5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Nov 9, 1878</u>		9. AGE (In years last birthday) <u>87</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William F. Rase</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Bauer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic H. disease</u> DUE TO (c) <u>perl. arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>diverticulitis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>64</u> , to <u>Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 22</u> 19 <u>66</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED <u>2/22/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisconsin Dr, Bethesda, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit 2-22-66</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Auburn, New York</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a. REC'D BY REGISTRAR <u>Feb 24 1966</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02556

02591

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>MONTGOMERY</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING TAKOMA PARK</i> c. LENGTH OF STAY IN 1b <i>1 DAY</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>WASHINGTON SAN & HOSP</i> <i>FAIRLAND NURSING HOME</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>MONTGOMERY</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SILVER SPRING</i> d. STREET ADDRESS <i>829 Philadelphia Avenue</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM WERTMAN RAHN</i>			4. DATE OF DEATH Month Day Year <i>2 - 1 - 1966</i>				
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-10-71</i>	9. AGE (In years last birthday) <i>94</i> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RET. PLATE PRINTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gov't</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Phila., Penna.</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			13. FATHER'S NAME <i>George RAHN</i>				
14. MOTHER'S MAIDEN NAME <i>Louise Nuremburg</i> <i>MORRIS METTLER CORRIDON</i>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No None</i>				
16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT <i>William A. Rahn</i> <i>829 Philadelphia Avenue Silver Spring, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive heart failure</i> DUE TO (c) <i>Loobar pneumonia, etc.</i>					INTERVAL BETWEEN ONSET AND DEATH <i>24-hrs</i> <i>1-2 days</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Generalized arteriosclerosis</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 23, 1965</i> to <i>Feb 1, 1966</i> that (I) (we) last saw the deceased alive on <i>Feb 1, 1966</i> , and that death occurred at <i>5 PM</i> , from the causes and on the date stated above.							
22a. SIGNATURE <i>John R. Spencer</i>				22b. DATE SIGNED <i>2-1-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>John R. Spencer</i>				22d. ADDRESS <i>BURTONSVILLE MD.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-4-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Hyattsville Maryland</i>			
24. FUNERAL DIRECTOR <i>Wagner E. Pumphrey, Inc.</i>		25a. RECEIVED BY REGISTRAR <i>FEB 6 1966</i>		25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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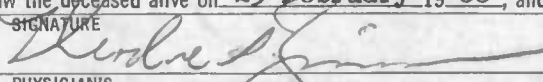
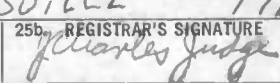
VR A15 (4)
15M 4-64

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02592

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02557

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 35 Days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring		15 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda 14, Md.				d. STREET ADDRESS 9808 Cottrell Terrace		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Richard Middle Arnold Last Ressler			4. DATE OF DEATH Month February Day 23 Year 19 66				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 April 1950		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Murray Ressler				14. MOTHER'S MAIDEN NAME Belle Simon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-48-9966		17. INFORMANT The Medical Record Address The Clinical Center, Bethesda 14, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Hypotension secondary to Klebsiella Sepsis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastrointestinal hemorrhage DUE TO (c) Acute Myelogenous Leukemia						INTERVAL BETWEEN ONSET AND DEATH 1 hour 24 hours 22 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XX (this hospital) attended the deceased from 19 January, 19 66 , to 23 February 66 , that XX (we) last saw the deceased alive on 23 February 19 66 , and that death occurred at 9:23 A. M, from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED 23 February 1966		22c. PHYSICIAN'S NAME (Type) Theodore S. Zimmerman, M.D.	
22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/24/66		23c. NAME OF CEMETERY OR CREMATORY MT. LEBANON CEM. PATTESVILLE MD		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR GOLOBERG FUNERAL HOME - 4217-9081				25a. REC'D BY REGISTRAR REC'D 25 1966		25b. REGISTRAR'S SIGNATURE 	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
SM 1/63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN 1b 2 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE New Jersey b. COUNTY WARREN c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phillipsburg d. STREET ADDRESS 115 Glen Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Anna Reyda 4. DATE OF DEATH February 3, 1966					9. AGE (In years last birthday) 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 8, 1901		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Malina	
14. MOTHER'S MAIDEN NAME Anna		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Yes		17. INFORMANT Steve Reyda*son		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Intracerebellar Hemorrhage DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c) 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					20c. TIME OF INJURY Month, Day, Year 19				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				
20f. (City or town)					20g. (County)				
20h. (State)					21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Belden R. Reap M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED Feb. 3, 1966					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Feb. 5, 1966				
22c. NAME OF CEMETERY OR CREMATORY St. Peter & St Paul					22d. LOCATION (City, town, or county) Alpha, New Jersey				
23. FUNERAL DIRECTOR C. E. Carter ADDRESS 8434 S. 5th					24a. REC'D BY REGISTRAR Charles Judge				
24b. REGISTRAR'S SIGNATURE					DATE FEB 7 1966				

1. **NAME** John Doe
 2. **DATE OF BIRTH** 12/15/1925
 3. **SEX** Male
 4. **AGE** 38
 5. **ETHNICITY** White
 6. **RELIGION** Catholic
 7. **EDUCATION** High School Graduate
 8. **OCCUPATION** Teacher
 9. **RESIDENCE** 123 Main St, New York, NY
 10. **TELEPHONE** 555-1234
 11. **DATE OF EXAMINATION** 10/10/1963
 12. **EXAMINER** Dr. J. Smith
 13. **TEST RESULTS**
 14. **REMARKS**
 15. **SIGNATURE**
 16. **DATE**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B92

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN IL <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi Silver Spring</u> d. STREET ADDRESS <u>1917 Rautan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Allie Wilson Richeson</u> First Middle Last				4. DATE OF DEATH <u>2 - 23 1966</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>7-3-97</u> Year Month Day				9. AGE (In years last birthday) <u>68</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Prof. of Md. University</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry Richeson</u> 14. MOTHER'S MAIDEN NAME <u>Edw. W. L. DUNN HATT</u> <u>Indith Durrett</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>220-36-6894</u>				17. INFORMANT <u>Mrs. R. Kathrine Richeson</u> Address <u>1917 Rautan St., S.S.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of liver</u> (b) <u>Carcinoma of prostate</u> (c) <u>177x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
19. INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>10-16</u> , 19 <u>61</u> , to <u>2-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-23</u> 19 <u>66</u> , and that death occurred at <u>1:05</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Eino Magi</u>				22b. DATE SIGNED <u>2-23-66</u>				22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>			
22d. ADDRESS <u>831 University Blvd E., Silver Spring, Md.</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-26-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>				24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> <u>4400 Georgia Avenue</u> <u>Silver Spring, Md.</u>							
25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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JAN 10 1964
U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 9 Film G374 3/3/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02595

02560

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Mont. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4710-Edgemore Lane</u>		d. STREET ADDRESS <u>4710- Edgemore Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>F.</u> Last <u>Ricketts</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 9, 1911</u>
9. AGE (In years lost birthday) yrs. <u>54 1/2</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles F. Ricketts</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Bennett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-1-10000</u>	
17. INFORMANT <u>Julian W. Ricketts/</u>		18. ADDRESS <u>214-1-10000 Woodland Rd. Rockville, Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage, right frontal with cerebral contusion.</u> DUE TO (b) <u>Skull fracture, left temporal</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down concrete steps in Apt. Bldg.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>Feb. 20 19 66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u> </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apt. Bldg.</u>		20f. (City or town) (County) (State) <u>Bethesda, Montgomery, Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>John G. Ball</u>		22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/23/66</u> Address (Street, city, town, or county) <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/26/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home 1331 Rockville Pike Rockville, Md.</u>		25. REC'D BY REGISTRAR <u>FEB 28 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10000

10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02596 CERTIFICATE OF DEATH 02561

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tenn.		b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 94 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Knoxville		79-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Naval Hospital Bethesda Md.				d. STREET ADDRESS 520 West Hill Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Donald Willard Ringgenberg		First Middle Last		4. DATE OF DEATH February 4 1966		Month Day Year	
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 August 1917	
9. AGE (In years last birthday) 48 yrs.		10. AGE (In years last birthday) 5 yrs.		11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Armed Forces		11. BIRTHPLACE (County & State, or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elmer Ringgenberg				14. MOTHER'S MAIDEN NAME Clara Sweet			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW II & Korea 546 40 4094		17. INFORMANT Florence Ringgenberg Knoxville Tenn.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of the stomach 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE L. Brettschneider				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 5 February 1966	
22c. PHYSICIAN'S NAME (Type) L. Brettschneider LT MC USN				22d. ADDRESS U.S. Naval Hospital Bethesda Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/8/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Robert A. Pumphrey Bethesda, Md.				25a. REC'D BY REGISTRAR FEB 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

08250

08250

U.S. Naval Hospital, Bethesda, Md.

James M. Smith, Jr.
Lieutenant, U.S. Navy
30 August 1947

U.S. Navy
Annapolis, Md.

U.S. Navy
30 August 1947

Enclosure

20

U.S. Navy

U.S. Navy

U.S. Navy

U.S. Navy

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02597

02562

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>68540-1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>3 mos.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLT CROSS HOSPITAL</u>				d. STREET ADDRESS <u>1912 Fox St.</u>			
3. NAME OF DECEASED (Type or print) First <u>JAMIE</u> Middle <u></u> Last <u>RITTER</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 17, 1965</u>	
9. AGE (In years last birthday) yrs. <u>3</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Stephen</u>				14. MOTHER'S MAIDEN NAME <u>Helena RHODA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>From child's chart (HOSP.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis (clinical)</u> <u>525X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>NOV 17, 1965</u> to <u>FEB 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB 20, 1966</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u> M.D.				22b. DATE SIGNED <u>2/20/66</u>		22c. PHYSICIAN'S NAME (Type) <u>ALLAN B. COLEMAN, MD</u>	
22d. ADDRESS <u>1605 N. PORTAL DR., NW, WASH. DC.</u>				22e. REC'D BY REGISTRAR <u>FEB 25 1966</u>		22f. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL MEMORIAL PARK FALLS CHURCH</u>		23d. LOCATION (City, town or county) (State) <u>VA.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>4217-928-1111</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and, in any event, within 72 hours after death.

 MEDICAL EXAMINER NOTIFIED 2/20/66
AND WILL APPROVE [Signature]

Interstitial pneumonia (clinical)

FOR STATE
HEALTH DEPT

02598

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02563

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
c. LENGTH OF STAY IN lb 3 hours		d. STREET ADDRESS 930 Emerson St., NW	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Michael Middle Rivers Last Rivers		4. DATE OF DEATH Month February Day 26 Year 1966	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/17/65
9. AGE (In years lost birthday) yrs. 3		IF UNDER 1 YEAR 3 Months 9 Days 9 Hours 9 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joe Louis Rivers		14. MOTHER'S MAIDEN NAME Bernardine Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 491X DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. L. Losp M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) BELDEN R. Losp, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Febr. 26, 1966		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 3-3-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Washington Funeral Chapel		25a. REC'D BY REGISTRAR 475 H. St. N. D.C.	
25b. REGISTRAR'S SIGNATURE Charles Judge		MAR 4 1966	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02599						02564					
Item #9 Film #4573 2/23/66											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN 1b <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS JANITORIUM</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u> 15-1 d. STREET ADDRESS <u>25 Froude Circle</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mazie E. Robey</u>						4. DATE OF DEATH Month Day Year <u>Feb 10 1966</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 1 1897</u>		9. AGE (In years last birthday) <u>89</u> yrs.		IF UNOER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>Thomas P. Wells</u>						14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>N/O</u>				16. SOCIAL SECURITY NO. <u>577-28-3509</u>		17. INFORMANT <u>MILDRED E. SHUFF</u>		Address <u>25 FROUDE CIRCLE CABIN JOHN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>plasma cell leukemia</u> <u>2040</u> OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>recent hip fx (12-65)</u>										INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2-8, 1966</u> to <u>2-10, 1966</u> , that (I) (we) last saw the deceased alive on <u>2-9, 1966</u> , and that death occurred at <u>12:35 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>H. P. Sengstack M.D.</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-10-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. P. SENGSTACK</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>				23d. LOCATION (City, town or county) (State) <u>SKITLAND MD</u>			
24. FUNERAL DIRECTOR <u>W. W. Chambers & Co.</u>						ADDRESS <u>517 11th ST SE. WASH D.C.</u>		25a. REC'D BY REGISTRAR <u>Feb 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

02501

02502

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "The", "and", "of", "in" are visible.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a vault within 72 hours after death.

4-18

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02600

CERTIFICATE OF DEATH

02566

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY in 1b 27 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arnold			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS Route 2, Box 18			
3. NAME OF DECEASED (Type or print) First Russell Middle Francis Last ROEDERER				4. DATE OF DEATH Month February Day 14 Year 19 66			
5. SEX male	6. COLOR OR RACE cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1916		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY U.S.N. Ret.		11. BIRTHPLACE (County & State, or foreign country) Wilton Junction, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Roederer				14. MOTHER'S MAIDEN NAME Elizabeth Klasser			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 554 26 4508		17. INFORMANT Address Mrs. Margaret Roederer, Route 2, Box 18 Arnold, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Left cerebral hemisphere infarction with arterial vascular thrombosis (c) Cerebral arteriosclerosis and arterio sclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from Jan. 18 , 19 66 , to Feb. 14 , 19 66 , that (1) (we) last saw the deceased alive on Feb. 14 , 19 66 , and that death occurred at 555A M, from causes and on the date stated above.							
22a. SIGNATURE Jay H. Miller, Jr.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jay H. Miller, Jr.				22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-1966	23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Va.		
24. FUNERAL DIRECTOR Taylor Funeral Home ADDRESS John M. Taylor 7-149 Gloucester St. Annapolis Md.				25a. REC'D BY REGISTRAR FEB 16 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

00280

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>												
02501 1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 39 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					02565 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Independent City c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 41 East Fort Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ronald Jerry Ross			4. DATE OF DEATH February 5 1966		5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 30 June 1945			9. AGE (in years last birthday) 20 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		11. BIRTH PLACE (County & State, or foreign country) Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic					10b. KIND OF BUSINESS OR INDUSTRY Unascertainable			13. FATHER'S NAME Robert P. Ross				
14. MOTHER'S MAIDEN NAME Pauline Middleton					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 225-56-3647			17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compression Inferior Vena Cava 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hodgkin's Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cachexia, progressive 10 months 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 28, 1966 , to February 5 1966 , that XX (we) last saw the deceased alive on February 5 1966 , and that death occurred at 7:15 AM , from the causes and on the date stated above. 22a. SIGNATURE Robert C. Gallo M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 5 February 1966 22c. PHYSICIAN'S NAME (Type) Robert C. Gallo, M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014										INTERVAL BETWEEN ONSET AND DEATH 3 months 10 months		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 2/8/66		23c. NAME OF CEMETERY OR CREMATORY Green Hill			23d. LOCATION (City, town or county) (State) Churchville, Virginia		
24. FUNERAL DIRECTOR Bear Funeral Home, Churchville, Va.					25a. REC'D BY REGISTRAR FEB 9 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

02207

Monetary

Belmont

30 days

The Clinical Center, Bethesda, Md. 20014

At East 1st Avenue

Ronald

Jerry

Rose

1st Street S

6

Male

White

30 June 1945

20

Nebraska

Unsubstantiated

Virginia

U.S.A.

Robert F. Ross

Leaving Station

The Medical Record

200-50-1007 The Clinical Center, Bethesda, Md. 20014

Compression Inferior Vena Cava

3 months

Hodgkin's Disease

10 months

Neurosis, Progressive

10 months

February 5, 1945

December 15, 1944

February 5, 1945

Robert U. Gallo, M.D.

The Clinical Center, Bethesda, Md. 20014
Investigator of Hodgkin's Disease

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. File pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02567											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park 15-1						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital					d. STREET ADDRESS 7001 Westmoreland Avenue						
3. NAME OF DECEASED (Type or print) First Lela Middle May Last Russell					4. DATE OF DEATH February 16, 1966						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-88		9. AGE (In years last birthday) 77 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry B. Worster					14. MOTHER'S MAIDEN NAME Margaret Brillhart						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive pulmonary embolism secondary to 9040 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fall and fracture of vertebral body.(L-1) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic adeno-carcinoma of uterus.									INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased fell while attempting to open a door at home.						
20c. TIME OF INJURY Month, Day, Year 9:30 a.m. 1/11 19 66					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Takoma Pk. Montg. Md.		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap					M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					22. DATE SIGNED Febr. 17, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Wheaton Address (street, city, town, or county) 254 Carroll N.W. D.C.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Feb. 21, 1966		23c. NAME OF CEMETERY OR CREMATORY Mallory Cemetery			23d. LOCATION (City, town or county) (State) Now Bridge Township, Mich			
24. FUNERAL DIRECTOR Arthur Walters					ADDRESS 254 Carroll N.W. D.C.		25a. REC'D BY REGISTRAR FEB 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

03203

03030

FEB 21 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02503 CERTIFICATE OF DEATH 02569

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN lb <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH SANIT. HOGA</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>13814 ROCKVILLE 15-1</u> d. STREET ADDRESS <u>13814 DRAKE DRIVE</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>HUGH BEUFORD SAMPSON, SR.</u> First Middle Last				4. DATE OF DEATH <u>2</u> <u>23</u> <u>1966</u> Month Day Year							
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-00</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u> <u>PET. WASH TERMINAL CO.</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HUGH B. SAMPSON</u>				14. MOTHER'S MAIDEN NAME <u>DAISY BELLE RIPPETOE</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>718-10-5728</u>		17. INFORMANT <u>Hugh B. Sampson, Jr.</u> Address <u>13814 Drake Dr. Rockville, Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>3561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AMYOTROPHIC LATERAL SCLEROSIS</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>FEB. 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>23 FEB. 1966</u> , and that death occurred at <u>4:08</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Morrill C. Quinnain, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-23-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinnain, Jr.</u>				22d. ADDRESS <u>Med. Bldg. University & Carroll Ave.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Falls Church, Virginia</u>					
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

00000

CERTIFICATE OF DEATH

00000

(M)

MAHARAJA STATE UNIVERSITY OF MEDICINE
FACULTY OF MEDICINE
DEPARTMENT OF MEDICINE
HOSPITAL
PATIENT'S NAME
AGE
SEX
DATE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
SIGNATURE OF PHYSICIAN
SIGNATURE OF WITNESSES
DATE OF DEATH
PLACE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02604

CERTIFICATE OF DEATH

02570

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>16-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLT CROSS HOSPITAL</u>		d. STREET ADDRESS <u>717 SHERIDAN ST.</u>	
3. NAME OF DECEASED (Type or print) <u>ABE SANDERS</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR-17-1892</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKBINDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVT.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>DAVID SANDERS</u>		14. MOTHER'S MAIDEN NAME <u>(UNKNOWN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>062-07-7900</u>	
17. INFORMANT <u>ELEN SANDERS</u>		Address <u>(see 2 above)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA PANCREAS</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u> <u>5 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>AUG.</u> , 19 <u>51</u> to <u>FEB.</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>24 FEB</u> 19 <u>66</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Henry R. Wolfe</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HENRY R. WOLFE</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GEORGE WASH. CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>HYATTSVILLE, MD.</u>
24. FUNERAL DIRECTOR <u>Deborah Spence</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1966</u>	
ADDRESS <u>4217 9th Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please place carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

05211

GROUP 27 OF 28

05204

1941

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY 47-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 1930 1st Street N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Lulu Middle R. Last SAUNDERS			4. DATE OF DEATH Month FEB Day 7 Year 1966			5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 23, 1872 9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR Months Days Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 10b. KIND OF BUSINESS OR INDUSTRY Indiana 11. BIRTHPLACE (County & State, or foreign country) Indiana 12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Edward S. Sanford						14. MOTHER'S MAIDEN NAME Frances E. Leonard					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Wayne Birdsell Address Silver Spg. Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESSENTIAL HYPERTENSION (c) GENERALIZED ARTERIOSCLEROSIS			INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town)			(County)			(State)		
21. I certify that (I) (this hospital) attended the deceased from MAY 10 , 19 59 , to FEB. 7 , 19 66 , that (I) (we) last saw the deceased alive on FEB 7 , 19 66 , and that death occurred at 7:15 PM , from the causes and on the date stated above.											
22a. SIGNATURE <i>Henry M. Lowden</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED FEB 7, 1966						22c. PHYSICIAN'S NAME (Type) Henry M. Lowden, M.D. 22d. ADDRESS 5206 Washington St. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF 2/10/66			23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery			23d. LOCATION (City, town or county) Washington, D. C. (State)		
24. FUNERAL DIRECTOR The S. H. Hines Co. ADDRESS 2901 14th St. N. W.						25a. REC'D BY REGISTRAR DATE FEB 10 1966 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

MEDICAL CERTIFICATION

05231

05203

MONTGOMERY

ANNALS

WASHINGTON, D. C.

CARROLL KELL SENTINEL

1030 1st Street N. E.

FEMALE WHITE

2007. 23. 10. 03

INDIANA

HOWARD, LINDSEY

FRANCIS, LINDSEY

NONE

NONE - 1110 N. 1st St. N. E.

HENRY H. LINDSEY

2/10/03

THE S. H. H. CO.

2001 1st St. N. E.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

02606

02572

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>5 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15 - 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bethesda-Silver Spring Nursing Home - Jones Mill Rd.</u>				d. STREET ADDRESS <u>10124 RANTAPPAH Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SELMA</u> Middle <u>S.</u> Last <u>SCHWARTZ</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 22, 1888</u>		9. AGE (In years last birthday) yrs. <u>77</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Bay, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rudolph Kneffer</u>				14. MOTHER'S MAIDEN NAME <u>Marie Schneider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Leonard Biggs</u> Address <u>2809 Dennis Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> <u>1530</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Adenocarcinoma, cecum with rupture and metastasis to lymph nodes and liver.</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>2/9/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Maryland</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02507

CERTIFICATE OF DEATH

02573

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN lb <u>8 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sharon Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>DC</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3407 29th St NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>William Neal Self</u>				4. DATE OF DEATH <u>February 23 1966</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 31- 1902</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Silk Spinner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Cleaning</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Ladonia, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Self</u>				14. MOTHER'S MAIDEN NAME <u>Jennie May McName (Swift)</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577 18 0122</u>		17. INFORMANT <u>Sharon Records</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>6-25, 1965</u> to <u>2-23, 1966</u> that (I) (we) last saw the deceased alive on <u>2-23, 1966</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Stanley M. Silverberg</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-24-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Stanley M. Silverberg, M.D.</u>				22d. ADDRESS <u>5201 Conn. Ave. N.W. Wash, D.C. 20015</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 26 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		23d. LOCATION (City, town or county) (State) <u>Woodfield Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6 days

Records

Sharon

577 18 0122

No

Mo.

Woodfield

Woodfield

Feb. 28 1966

Burial

Mo.

Laytonsville

H. Raper

Francis H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02608										02574			
CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montg</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>12009 Viers Mill Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>C.</u> Last <u>SELLERS</u>			4. DATE OF DEATH Month <u>FEB</u> Day <u>25</u> Year <u>1966</u>			5. SEX <u>FEMALE</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>11-3-1900</u>			9. AGE (In years last birthday) <u>65</u> yrs.			IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u> Hours <u>1</u> Min.		IF UNDER 24 HRS. Hours <u>1</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George H. Carter</u>						14. MOTHER'S MAIDEN NAME <u>Margaret McNeil</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>414-54-6048</u>			17. INFORMANT <u>Warren H. Sellers, husband - same item # 2</u>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR CATASTROPHE, PROBABLY TRANSIENT</u> 332x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIO SCLEROSIS, CEREBRAL + SYSTEMIC</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ORGANIC HEART DISEASE, PROBABLY COR PULMONAE</u>												INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>10/23/</u> , 19 <u>50</u> , to <u>2/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>66</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Charles Farwell</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2/25/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>Charles Farwell</u>						22d. ADDRESS <u>11406 Viers Mill Rd., Wheaton, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>2/28/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>			23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>				
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>						1331 ADDRESS <u>Rockville Pike</u>			25a. REC'D BY REGISTRAR <u>Charles Judge</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Funeral Home						Rockville, Maryland			DATE <u>MAR 1 1966</u>				

15034

2003

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2003



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B.P.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
02575													
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN b <u>5 hrs - 31 m</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>15-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby Boy Simms</u> First Middle Last						4. DATE OF DEATH <u>Feb. 18 1966</u> Month Day Year							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/66</u>		9. AGE (In years last birthday) <u>2</u> yrs. <u>3</u> months <u>31</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
						11. BIRTHPLACE (County & State, or foreign country) <u>Ind.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>					
13. FATHER'S NAME <u>Larry Simms, Jr.</u>						14. MOTHER'S MAIDEN NAME <u>Winifred Fay</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 7736 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c) <u>—</u>												INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>2/15</u> , 19 <u>66</u> , to <u>2/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>66</u> , and that death occurred at <u>—</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Albert J. Modlin</u>								22b. DATE SIGNED <u>2-18-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Albert J. Modlin</u>								22d. ADDRESS <u>704 Gorman Ave. Laurel, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial</u>		<u>2/19/66</u>		<u>Gate of Heaven</u>		<u>Silver Spring, Md.</u>							
24. FUNERAL DIRECTOR <u>Kypon Wheeler</u>						25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
ADDRESS <u>1331 Rockville Pike Rockville, Md.</u>													

00000

Montgomery

Chlorophyll

2100-3100

High Growth of Chlorophyll

Body of

2100-3100

male white

2100-3100

Large 2100-3100

2100-3100

Albert J. Mobilia

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02610

Item #11 & 12 Film #G373 2/23/66 pc

CERTIFICATE OF DEATH

02576

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>3 days</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium Hospital</u>			d. STREET ADDRESS <u>869 Northampton Drive</u>		
3. NAME OF DECEASED (Type or print) <u>Sadie Browne Simpson</u>			4. DATE OF DEATH <u>February 12, 1966</u>		
5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>January 21, 1889</u>		
9. AGE (in years last birthday) <u>77</u> yrs.			10. IF UNDER 1 YEAR <u>77</u> Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Loudar County, Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Connor</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>Washington Sanitarium Records</u>		
17. INFORMANT <u>Washington Sanitarium Records</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 1966, to <u>2/12</u> , 1966, that (I) (we) last saw the deceased alive on <u>2/12</u> , 1966, and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Richard H. Pollen</u>			22b. DATE SIGNED <u>2/12/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>			22d. ADDRESS <u>10511 SUMMIT AVE KENSINGTON, MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb 16, 1966</u>		
23c. NAME OF CEMETERY, OR CREMATORY <u>George Washington Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Adephi Pk. Rev Co. Md</u>		
24. FUNERAL DIRECTOR <u>Arthur Waters</u>			25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>		
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

05230

05230

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint handwritten text at the bottom of the page, including what appears to be a signature and date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2d, 7, 14, 17 Film G574 5/7/66 mh

02611

CERTIFICATE OF DEATH

02577

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS 9031 / 9103 Contee Rd.	
3. NAME OF DECEASED (Type or print) First Helen Middle Rice Last Smith		4. DATE OF DEATH Month February Day 20 Year 19 66	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 17 August 1902
9. AGE (In years) 63 birthday yrs.		10. IF UNDER 1 YEAR Months 6 Days 3 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Calif. Public Schools	
11. BIRTHPLACE (County & State, or foreign country) Granite City, Ill.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William B. Rice		14. MOTHER'S MAIDEN NAME Eunice Emma Lenore Schwald	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 536059040A	
17. INFORMANT Mary Lou Linstedt		18. ADDRESS 9031 / 9103 Contee Rd. Laurel, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma breast with widespread metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (A) (this hospital) attended the deceased from Feb. 2 , 19 66 , to Feb. 20 , 19 66 that (A) (we) last saw the deceased alive on Feb. 20 , 19 66 , and that death occurred at 510p M, from causes and on the date stated above.			
22a. SIGNATURE C. P. Kessler		22b. DATE SIGNED Feb. 21, 1966	
22c. PHYSICIAN'S NAME (Type) C. P. Kessler LT MC USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Transit		23b. DATE THEREOF 2-22-66	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Los Angeles, California	
24. FUNERAL DIRECTOR R. A. Pumphrey		25a. REC'D BY REGISTRAR FEB 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 7557 Wisconsin Avenue Bethesda, Maryland	

115521

05217



115521
05217

115521 05217

FOR STATE
HEALTH DEPT.

02612

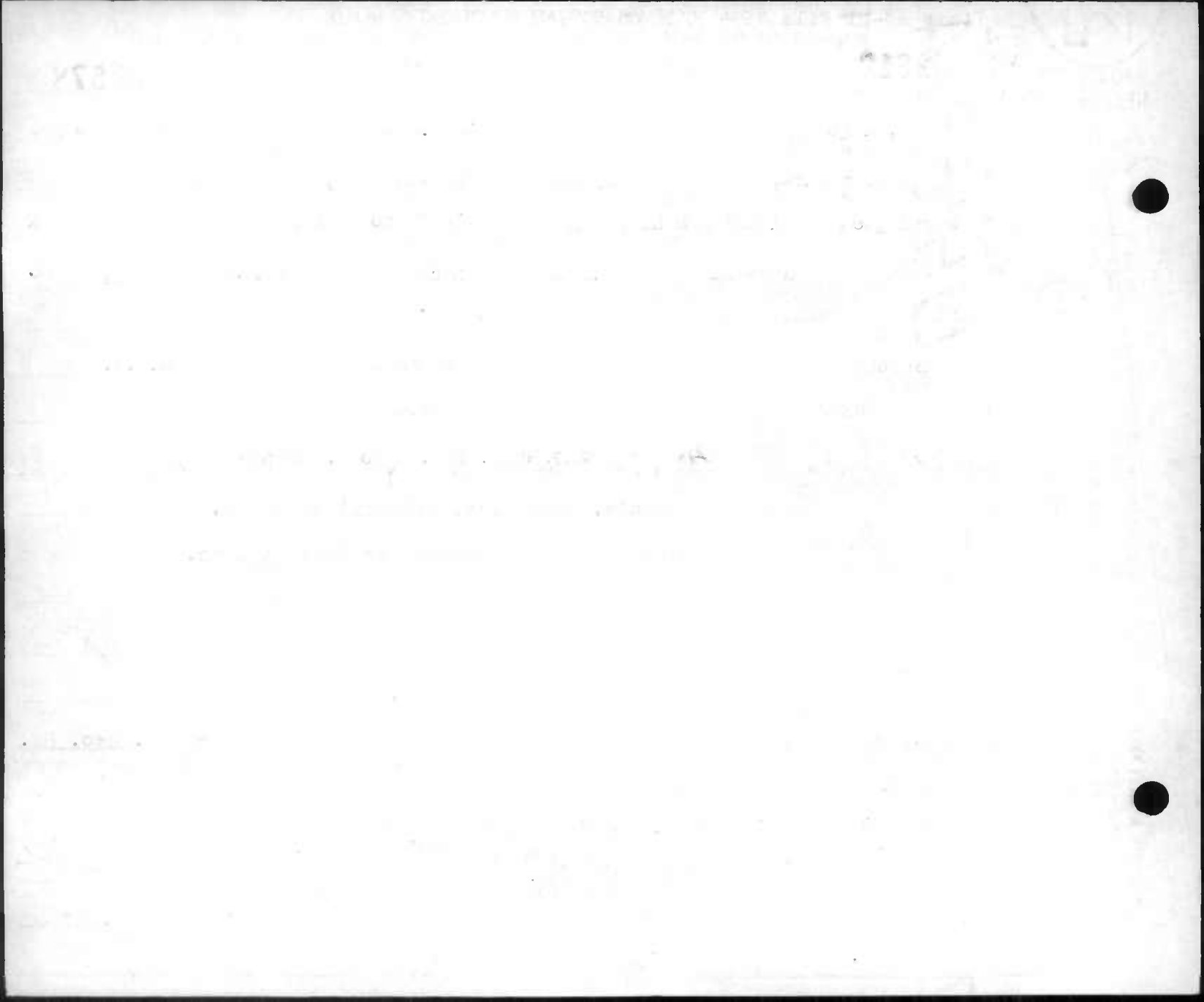
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02578

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park,				c. LENGTH OF STAY IN 1b 23 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				e. STREET ADDRESS 2422 Hannon Street			
3. NAME OF DECEASED (Type or print) First Russell Middle Martin Last Snyder				4. DATE OF DEATH Month February Day 23 Year 19 66			
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-84	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edgar				14. MOTHER'S MAIDEN NAME Booker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 214-19-2004		17. INFORMANT Wash. San. & Hosp. Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic, extensive, subdural hematoma, DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) left cerebrum, incurred in fall at home. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased fell at home.				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11:00 PM 1/29 19 66			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hyattsville Pr. Geo. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED Febr. 23, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/16/66		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Md.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.			ADDRESS		25a. RECEIVED BY REGISTRAR Feb 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02613

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02579

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 41 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee b. COUNTY Bristol c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 79-3 d. STREET ADDRESS 701 Alabama Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daniel Paul Sowards		4. DATE OF DEATH Month Day Year February 23 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 23 May 1926
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Unascertainable	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel B. Sowards		14. MOTHER'S MAIDEN NAME Nancy B. Bates	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 236-30-9744	
17. INFORMANT The Medical Record		Address The Clinical Center, Bethesda, Md. 20014	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anticoagulation and Congestive Heart Failure DUE TO Idiopathic myocardopathy and (c) recurrent pulmonary emboli PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH 4 days 2 months 2 months			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from January 13, 1966 , to Feb. 23, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 23, 1966 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE R. Buccino MD		22b. DATE SIGNED 24 February 1966	
22c. PHYSICIAN'S NAME (Type) Robert Buccino, M.D.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 2-25-66	
23c. NAME OF CEMETERY OR CREMATORY Huntington, West Va.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Fraziers Funeral HOME -Washington, D.C.		25a. REC'D BY REGISTRAR FEB 28 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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The Clinical Center, Bethesda, Md. 20814

Chief, P. O. Box 1200

Chief, P. O. Box 1200

The Clinical Center, Bethesda, Md. 20814

The Clinical Center, Bethesda, Md. 20814

The Clinical Center, Bethesda, Md. 20814

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TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

(M)

(I)

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH			
5. SEX				6. COLOR OR RACE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				B. DATE OF BIRTH			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (County & State, or foreign country)			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.			
17. INFORMANT				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY				20d. INJURY OCCURRED			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)			
20g. (County)				20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from..... to....., 1966, that (I) (we) last saw the deceased alive on....., and that death occurred at..... M, from the causes and on the date stated above.							
22a. SIGNATURE				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county)			
24. FUNERAL DIRECTOR'S SIGNATURE				25. REC'D BY REGISTRAR			
25a. ADDRESS				25b. REGISTRAR'S SIGNATURE			

02614

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02580

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY	MONTGOMERY	a. STATE	MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	BETHESDA	b. COUNTY	Montgomery
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Bethesda
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	RESMORE SANITARIUM AND HOSPITAL	d. STREET ADDRESS	9411 Holland Avenue Bethesda, Maryland
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	George F. Spier	4. DATE OF DEATH	2 / 28 1966
5. SEX	FEMALE	6. COLOR OR RACE	White
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH	6 March 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Practiced nurse	11. BIRTHPLACE (County & State, or foreign country)	Minnesota
13. FATHER'S NAME	GEORGE WOOLFORD	14. MOTHER'S MAIDEN NAME	Florence Rieder
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	579-38-7593
17. INFORMANT	Mrs. Max Wilfand--same item #2--Daughter	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	Liver Failure & Pulmonary Edema Metastatic Ca to the liver from site unknown		
INTERVAL BETWEEN ONSET AND DEATH	1 day 2 mo.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a.m. p.m.	19	While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20f. (City or town)
20g. (County)	20h. (State)		
21. I certify that (I) (this hospital) attended the deceased from..... to....., 1966, that (I) (we) last saw the deceased alive on....., and that death occurred at..... M, from the causes and on the date stated above.	Feb 14, 1966 to Feb 28, 1966, that (I) (we) last saw the deceased alive on Feb 28, 1966, and that death occurred at 11:55 P.M. from the causes and on the date stated above.		
22a. SIGNATURE	W. John Moore	22b. DATE SIGNED	2/28/66
22c. PHYSICIAN'S NAME (Type)	W. TAGO MOORE	22d. ADDRESS	2001 I St N.W. Wash. D.C.
23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE THEREOF	3/3/66
23c. NAME OF CEMETERY OR CREMATORY	Rockville	23d. LOCATION (City, town or county)	Rockville, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE	Tyson Wheeler	25a. ADDRESS	1331 Rockville Pike, Rockville, Md
25b. REGISTRAR'S SIGNATURE	Charles Judge	25c. REC'D BY REGISTRAR	MAR 3 1966

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4 yrs-11 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1029 Tenley Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Annie Davey Stack</u> First Middle Last			4. DATE OF DEATH <u>February 4</u> 19 <u>66</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 1870</u> <u>95</u> <u>96</u> yrs. 9. AGE (In years last birthday) <u>95</u> <u>96</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Patrick Davey</u> 14. MOTHER'S MAIDEN NAME <u>Maria Supple</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>James H. Stack</u> Address <u>1029 Tenley Road Silver Spring, Maryland</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from <u>Mar. 22</u> , 19 <u>61</u> , to <u>Feb. 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3</u> , 19 <u>66</u> , and that death occurred at <u>5:45</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Thomas J. Kelly</u> 22b. DATE SIGNED <u>2-4-66</u> 22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Kelly</u> 22d. ADDRESS <u>6480 N. H. Ave., Takoma Park, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-8-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Queens, New York City, N. Y.</u>		24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u> 25a. REC'D BY REGISTRAR <u>FEB 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

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Fairland Farming House

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David

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William Stack

David

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Montgomery

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1024 Tenley Road

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02616						CERTIFICATE OF DEATH						02582		
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN 1b 2 mo. 14 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 9217 Scott Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) CARRIE P. STARRATT			4. DATE OF DEATH FEBRUARY 14 1966			5. SEX F			6. COLOR OR RACE Cauc.			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH 11/4/1880			9. AGE (In years last birthday) 85			IF UNDER 1 YEAR 4 Months 10 Days 10 Hours 10 Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY home		
11. BIRTHPLACE (County & State, or foreign country) Mississippi						12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME James M. Pickens						14. MOTHER'S MAIDEN NAME Sadie Williams								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. Unknown						17. INFORMANT Mr. Andrew Starratt		
						Address 9217 Scott Drive								
						City Rockville								
						State Md.								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERALIZED ARTERIOSCLEROSIS												INTERVAL BETWEEN ONSET AND DEATH 15 MINUTES		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SENILITY												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
						20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from NOV. 30, 1965 , to FEB. 14, 1966 , that (I) (we) last saw the deceased alive on FEB. 14, 1966 , and that death occurred at 11:10 M. from the causes and on the date stated above.														
22a. SIGNATURE Henry M. Lowden, M.D.												22b. DATE SIGNED FEB. 14, 1966		
22c. PHYSICIAN'S NAME (Type) Henry M. Lowden, M.D.												22d. ADDRESS 5206 NORWAY DR. CHEVY CHASE, MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/17/66				23c. NAME OF CEMETERY OR CREMATORY Rockville Union Cem.				23d. LOCATION (City, town or county) (State) Rockville, Md.		
24. FUNERAL DIRECTOR Robert A. Pumphrey						ADDRESS Bethesda, Md.						25a. REC'D BY REGISTRAR FEB 17 1966		
						25b. REGISTRAR'S SIGNATURE Charles Judge								

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Montgomery
Remington
General Hall
9217 North Drive

James M. Edwards
Houswife
11/1/1960
USA

Unknown Mr. Andrew Stewart
9217 North Drive

Robert A. Humphrey
Houswife
11/1/1960
USA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02583

02617

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>Entire life</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 Elm Avenue</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> <u>15-1</u> d. STREET ADDRESS <u>110 Elm Street Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Florence</u> Middle <u>Steadman</u> Last				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 14, 1896</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James F. Phillips</u>		14. MOTHER'S MAIDEN NAME <u>Sarah C. Giddings</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>218.20.1393</u>		17. INFORMANT <u>Belva Shaw - 108 Elm St.</u>		Address <u>Takoma Park Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Chronic glomerular nephritis</u> DUE TO (c) <u>Arteriosclerosis -</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November, 1964</u> , to <u>February 6, 1966</u> , that I last saw the deceased alive on <u>February 6, 1966</u> , and that death occurred at <u>12:57 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. Clarence Rice</u> M.D.				ADDRESS (Street, city or town, state) <u>1150 Conn. Ave., N.W.</u> DATE SIGNED <u>February 6, 1966</u>			
PHYSICIAN'S NAME (Type) <u>E. CLARENCE RICE</u>				<u>Washington, D.C. 20036</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 10, 1966</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Takoma Funeral Home Inc</u>				ADDRESS <u>254 Carroll St</u>		24a. REC'D BY REGISTRAR <u>John Charles Judge</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>FEB 9 1966</u>			

CERTIFICATE OF DEATH

Page One

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
02618									
02584									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE D. C. b. COUNTY Washington				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring					c. LENGTH OF STAY IN 1b 29 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Montgomery Convalescent & Nursing Home					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington				
3. NAME OF DECEASED (Type or print) HILDA Vernon					4. DATE OF DEATH FEB 2 1966				
5. SEX FEMALE 6. COLOR OR RACE White					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Aug. 21, 1883				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (RETIRED)					10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt-Treasury				
13. FATHER'S NAME Edward Schaeffer					14. MOTHER'S MAIDEN NAME Rose Drury				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no					17. INFORMANT Mont. Conv. & Nursing Home				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) C.V.A. 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) cerebro-vascular A.S. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 3 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ASHD, chronic atrial fibrillation									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from 1-15 1966 to 2-2 1966 that (1) (we) last saw the deceased alive on 2-2 1966 , and that death occurred at 5 P.M. from the causes and on the date stated above.									
22a. SIGNATURE George F. Sengstack M.D.					22b. DATE SIGNED 2-3-66				
22c. PHYSICIAN'S NAME (Type) George F. Sengstack					22d. ADDRESS 9241 Col. Blvd. Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 2-4-66				
23c. NAME OF CEMETERY Mount Olivet					23d. LOCATION (City, town or county) (State) Washington, D. C.				
24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins					25a. REC'D BY REGISTRAR 7-7-66				
25b. REGISTRAR'S SIGNATURE Charles Judge					25c. DATE FEB 7 1966				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02819 CERTIFICATE OF DEATH 02585

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4212 Stanford Street			d. STREET ADDRESS 4212 Stanford Street		
3. NAME OF DECEASED (Type or print) First Ralph Middle B Last Stewart			4. DATE OF DEATH Month Feb. Day 21 Year 1966		
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/27/1894	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR Months 8 Days 24 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Patent Lawyer			10b. KIND OF BUSINESS OR INDUSTRY Law		11. BIRTHPLACE (County & State, or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Twyman Clark STEWART		
14. MOTHER'S MAIDEN NAME Malinda Babb			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		
16. SOCIAL SECURITY NO. 215-38-5828			17. INFORMANT Clark B. Stewart		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH Immediate		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3/9/59 , to 2-21 , 19 66 , that (I) (we) last saw the deceased alive on 12-27 19 65 , and that death occurred at 7:15 P M, from the causes and on the date stated above.					
22a. SIGNATURE John A. Reisinger			22b. DATE SIGNED 2/21/66		
22c. PHYSICIAN'S NAME (Type) John A. Reisinger, M.D.			22d. ADDRESS 1835 Eyo St. N.W.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/25/66		
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem. Arlington, Va.			23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR Robert A. Pumphrey			25a. REC'D BY REGISTRAR FEB 25 1966		
25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02620						Item #8 Film #G373 2/11/66						02586	
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney md</u>				c. LENGTH OF STAY IN 1b <u>1/26-66 - 2/5-66</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney md</u>				15-1			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San & Hosp.</u>						d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Warren Stimpson</u>			4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1966</u>										
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-9-85</u>		9. AGE (In years last birthday) <u>81</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumberman</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New Hampshire</u>				12. CITIZEN OF WHAT COUNTRY? <u>Amer.</u>			
13. FATHER'S NAME <u>Leander Stimpson</u>						14. MOTHER'S MAIDEN NAME <u>Ann unknown Dexter</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>143-18-8203</u>		17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Benign Prostatic Hypertrophy with obstructive uropathy</u>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that (I) (this hospital) attended the deceased from <u>1-26</u> , 19 <u>66</u> , to <u>2-5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>FEB 5 1966</u> , and that death occurred at <u>9 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Richard H. Pollen</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-6-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>						22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON, MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Feb. 8 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Bostonville Md</u>			
24. FUNERAL DIRECTOR <u>Arthur Walters</u>						ADDRESS <u>254 Canal St NW DC</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

W. J. S. O.

X

17-28-9-7

Handwritten signature: *Handwritten signature*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> 15-1				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>						d. STREET ADDRESS <u>8009 Sligo Creek Parkway</u>					
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Newton</u> Last <u>Stottlemeyer</u>						4. DATE OF DEATH <u>February</u> <u>22</u> <u>19 66</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 5, 1902</u>		9. AGE (in years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Policeman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Police Dep't.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Boys, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Milton Uner Stottlemeyer</u>						14. MOTHER'S MAIDEN NAME <u>Lulu Thompson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-38-9387</u>		17. INFORMANT <u>Leonard Stottlemeyer</u> Address <u>Jakoma Park, Md. 8009 Sligo Creek Pkwy</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) diabetes 2) congestive heart failure</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/1/66</u> , 19 <u>66</u> , to <u>2/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/21/66</u> 19 <u>66</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Patrick C. Jameson</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 22, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Patrick Jameson, M.D.</u>						22d. ADDRESS <u>11718 Georgia Ave., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 26, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince George County MD</u>			
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Coronary + bronchial

1) *Arabis* 2) *Campanula*

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

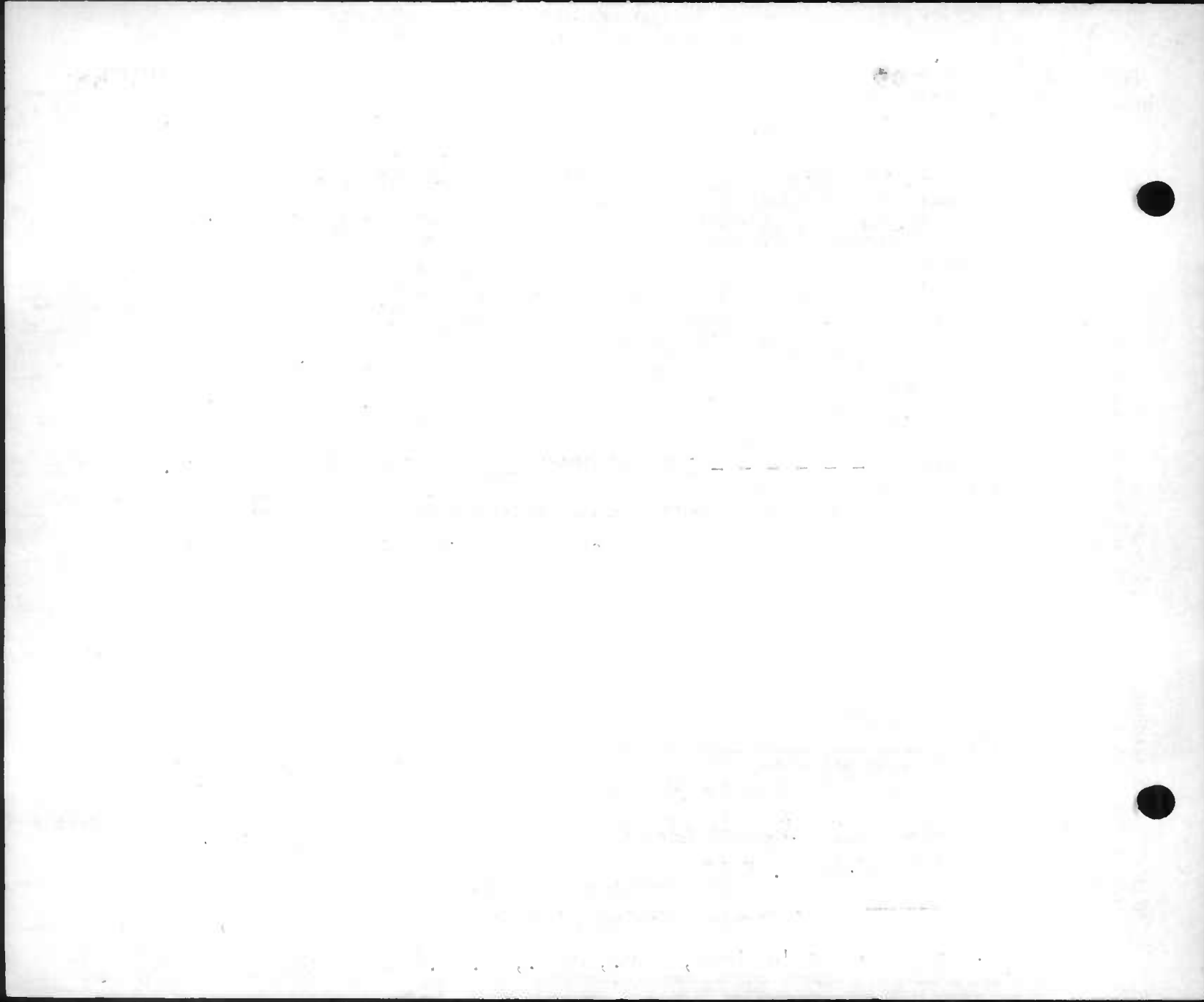
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02588

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9498 Singleton Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED First Middle Last <u>JANE M STUART</u>		4. DATE OF DEATH Month Day Year <u>Feb. 6 1966</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1914</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Law.</u>	
13. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		14. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. FATHER'S NAME <u>George T. Stuart</u>		16. MOTHER'S MAIDEN NAME <u>Helen M. Manderville</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		18. SOCIAL SECURITY NO. <u>120 03 5287</u>	
19. INFORMANT <u>Brother</u>		Address <u>9498 Singleton Dr. Bethesda</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno Carcinoma - Ovaries with</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastasis: Extensive to Colon, Liver, Spleen</u> DUE TO (c) <u>2 Mo.</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/7/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>2/8/1966</u>	23b. DATE THEREOF <u>2/8/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc., Wash., D. C.</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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16
FOR STATE
HEALTH DEPT.

02523

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02589

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u></u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ARLINGTON</u> 83-3	
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		d. STREET ADDRESS <u>12779 Kings Steeple</u> 4408 4th RD. YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bethesda Naval Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clairborne</u> Middle <u>Mason</u> Last <u>Talley</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15, 1982</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF FUNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M. Talley</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Tompkins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes - 1917-1945</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u></u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute.</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u></u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 2/20/66	
22. DATE SIGNED		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 24, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Ives Funeral Home, Inc.</u> by: <u>Don E. Rogers Jr.</u>		ADDRESS <u>2847 Wilson Blvd.</u> <u>Arlington, Va.</u>	
25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

08230

08230

Arlington, Virginia

Rep. SA. 1000 Arlington National Cem.

United

Ivan Funeral Home, Inc. 2217 Wilson Blvd.
Arlington, Va.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02624

02590

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chevy Chase 15-1 d. STREET ADDRESS 26 Grafton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL B. TAYLOR		4. DATE OF DEATH Feb. 1, 1966		5. SEX Male	
6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12, 1905	
9. AGE (In years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreign Sec.-State Dept.-Govt		11. BIRTHPLACE (State or foreign country) Nebraska	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Joseph E. Taylor		14. MOTHER'S MAIDEN NAME Anna Bennett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 083-36-1598		17. INFORMANT Wife Katrina Taylor Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute - 4201 DUE TO (b) Cardio Vascular Disease - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) Years					INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(s)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE John S. Ball		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 2-1-66	
EXAMINER'S NAME (Type) John G. Ball		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2-1-66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
23d. LOCATION (City, town or county) Suitland, Maryland		23e. REC'D BY REGISTRAR FEB 4 1966			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		ADDRESS Bethesda, Maryland		25. REGISTRAR'S SIGNATURE John Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>21 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SAN. & Hosp</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONT</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>8206 HOUSTON COURT 15-1</u> d. STREET ADDRESS <u>APT 1 TAKOMA PK.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>DIMONT LESTER TERRELL</u> First Middle Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-15-14</u> 9. AGE (In years last birthday) <u>51</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief - assembler</u> 11. BIRTHPLACE (County & State, or foreign country) <u>S.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>CHARLES T. TERRELL</u> 14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>NEVA B. TERRELL</u> Address <u>1606 Records - SAME AS #2</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5811 Acute hemorrhagic pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>possible penetrating duodenal ulcer</u> (c) <u>Lactonesis cinchon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>24 hours</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>2/2</u>, 19<u>66</u>, to <u>2/23</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2/23</u>, 19<u>66</u>, and that death occurred at <u>9A</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Kenneth Cruz</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2/23/66</u> 22c. PHYSICIAN'S NAME (Type) <u>KENNETH CRUZ</u> 22d. ADDRESS <u>1600 CARROLL AVE TAKOMA PARK, MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2/28/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>GREEN POND</u> 23d. LOCATION (City, town or county) (State) <u>CLIMAX, VA.</u> 24. FUNERAL DIRECTOR <u>W. W. Chambers CO</u> ADDRESS <u>8635 2nd Ave Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>1 FEB 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>											

10031

2222

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02626

CERTIFICATE OF DEATH

02592

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		d. STREET ADDRESS <u>5010 Randolph Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>David Peter</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25, 1913</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>G.V. Producer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary Pinto</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Wife - Dorothy - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO <u>6 weeks</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> to <u>Feb</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2 Feb</u> 19 <u>66</u> , and that death occurred at <u>10 A.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>David P. Thomas</u>		22b. DATE SIGNED <u>6 Feb 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>David P. Thomas</u>		22d. ADDRESS <u>5201 Randolph Rd. Rockville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-9-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington, Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>		DATE <u>FEB 11 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03206

03206

10 AUGUST 1970

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02627

02594

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>12 days</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>15-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium - Hospital</u>						d. STREET ADDRESS <u>1110 Briggs Cheney Road</u>			
3. NAME OF DECEASED (Type or print) <u>Marie Catherine Thompson</u>			4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1966</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-10-10</u>		9. AGE (in years last birthday) <u>55 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocery Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Merch.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Rickells</u>				14. MOTHER'S MAIDEN NAME <u>Lena Speck</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records Washington Sanitarium - Hospital</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/13/66</u> , 19 <u>66</u> , to <u>2/25/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/25/66</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph E. Smith, Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/25/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Smith, Jr.</u>				22d. ADDRESS <u>Burtonsville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u>		23d. LOCATION (City, town or county) (State) <u>Sunshine, Md.</u>			
24. FUNERAL DIRECTOR <u>Francis H. Barber</u>				ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

05731

05731

x

Gen. Merch.

Acute Myocardial Infarction
Arteriosclerotic Heart Disease

2/1/68
2/1/68
2/1/68
2/1/68
2/1/68

Joseph E. Smith, Jr.
Joseph E. Smith, Jr.

Washington, Md.

Mt. Carmel

2-28-68

Burial

Laytonville, Md.

Barber Laytonville, Md.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02628

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02595

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>4 mos.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10510 New Hampshire Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>FERN SALESTIA THORNHILL</u>		4. DATE OF DEATH <u>February 16, 1966</u>		5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>3-30-1899</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>10</u> Days <u>16</u> Hours <u>16</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Store Mgr. Clothing</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Missouri</u>				11. BIRTHPLACE (State or foreign country) <u>Mo.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Alanzo A. Thornhill</u>				14. MOTHER'S MAIDEN NAME <u>Honey McCall</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <u>262-05-0682</u>			
17. INFORMANT <u>Records (Nursing Home)</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension, Essential</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Belden R. Leaf</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22. DATE SIGNED <u>Febr. 16, 1966</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF											
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)											
<u>Burial-transit 2/18/66</u>				<u>Marionville Cemetery Marionville, Missouri</u>											
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>															

112307

28029

[Faint, mostly illegible handwritten text, possibly a letter or report, with several 'X' marks.]

[Faint, mostly illegible handwritten text at the bottom of the page, including what appears to be a signature and date.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
02629					CERTIFICATE OF DEATH					02596				
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN 1b 73 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda, Md. 20014					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE California b. COUNTY Glendora c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 833 East Leadora Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Carol Leigh Thornton					4. DATE OF DEATH February 24 1966									
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8 November 1936 29 yrs.		9. AGE (In years last birthday) 29		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher					10b. KIND OF BUSINESS OR INDUSTRY Unascertainable		11. BIRTHPLACE (County & State, or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Milton Gvirtsman					14. MOTHER'S MAIDEN NAME Katherine Lefkowitz									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 551-68-3831		17. INFORMANT The Medical Record			Address The Clinical Center, Bethesda, Md. 20014				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choriocarcinoma, widespread; lungs, chest wall/brain, 173X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH 2 Years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 13, 1966 to Feb. 24, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 24, 1966 , and that death occurred at 11:50 P.M. , from the causes and on the date stated above.														
22a. SIGNATURE D. G. Liegler					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 25 February 1966						
22c. PHYSICIAN'S NAME (Type) Donald G. Liegler, MD.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-1-1966		23c. NAME OF CEMETERY OR CREMATORY W.W. Chambers Co 1400 Chapin St N.W. Washington D.C.				23d. LOCATION (City, town or county) (State) GLENDORA CALIF						
24. FUNERAL DIRECTOR W.W. Chambers Co					ADDRESS 1400 Chapin St N.W. Washington D.C.		25a. REC'D BY REGISTRAR MAR 2 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge					

100000

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California

California

San Francisco

San Francisco

San Francisco

The California Center, 333 Sanson Street, San Francisco, CA 94102

Telephone

Telephone

Telephone

Yours truly,
[Signature]

Very truly yours,
[Signature]

Very truly yours,
[Signature]

Enclosed for you are two copies of the report.

Very truly yours,
[Signature]

Very truly yours,
[Signature]

Very truly yours,
[Signature]

Very truly yours,
[Signature]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02630

CERTIFICATE OF DEATH

02597

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY in 1b <u>5+ mths</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7414 Birch Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 15-1</u> d. STREET ADDRESS <u>7414 Birch Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CLAUDE D. TICHENOR</u>		4. DATE OF DEATH Month Day Year <u>Feb. 4 1966</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 16, 1889</u>			
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler - Steel</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Centertown, Kentucky</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Tichenor</u>		14. MOTHER'S MAIDEN NAME <u>Martha Rowe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Olive A. Tichenor, (same as #2)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		(County) _____		(State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>October 1965</u> to <u>2-4</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2-4</u>, 19<u>66</u>, and that death occurred at <u>12:45</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Morris Perry</u>		22b. DATE SIGNED <u>2-4-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Morris Perry</u>			
22d. ADDRESS <u>11602 Georgia Ave Silver Spring Md.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. ADDRESS _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>			
23d. LOCATION (City, town or county) <u>Newburgh, Indiana</u>		(State) _____		24. FURNERAL DIRECTOR'S SIGNATURE <u>Arthur Walton</u>			
24a. ADDRESS <u>254 Carroll St NW. DC</u>		25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02631

CERTIFICATE OF DEATH

02598

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (rural)</u>		c. LENGTH OF STAY IN lb <u>6 hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>		83-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		d. STREET ADDRESS <u>1735 14th Road, South</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Kevin</u> Last <u>Tinney</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 28, 1966</u>
9. AGE (In years lost birthday) yrs. <u>6</u>		10. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u>	11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>William E. Tinney</u>		14. MOTHER'S MAIDEN NAME <u>Marguerite Kennedy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>William E. Tinney, 1735 14th Road, South/</u>		Address <u>Arlington, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>Respiratory distress syndrome, prematurity</u> IMMEDIATE CAUSE (a) <u>2735</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 28</u> , 19 <u>66</u> , to <u>Feb. 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 28</u> 19 <u>66</u> , and that death occurred at <u>1140A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. I. Lynch</u>		22b. DATE SIGNED <u>Mar. 1, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. I. Lynch, M.D.</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3-3-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Falls Church Funeral Home, 1102 West Broad St</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 3 1966</u>	

155

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery 9710-Saxony-Rd.,						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home					d. STREET ADDRESS 9710 Saxony Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Ida Lillian Titelman			First Middle Last		4. DATE OF DEATH Feb. 22 1966		Day Month Year				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/9/1890		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months 2 Days 11 Hours 15 IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME JOSEPH LEVINE					14. MOTHER'S MAIDEN NAME KATE ROMAN						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16. SOCIAL SECURITY NO. 110NE		17. INFORMANT 9710 SAXONY RD. SILVER SPRING, MD. MORTON TITELMAN						
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic colon 1538 DUE TO metastasis to urinary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO bladder & hemorrhage (b) (c)								INTERVAL BETWEEN ONSET AND DEATH 4 yrs. 8 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Feb 22 1966				
21. I certify that (I) (this hospital) attended the deceased from Feb 22 1966 to Feb 22 1966 that (I) (we) last saw the deceased alive on Feb 22 1966 and that death occurred at 3:15 PM from the causes and on the date stated above.											
22a. SIGNATURE IRVING BROITMAN, M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1946 K ST. N.W.				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 4217 9th St NW WASH DC									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/24/66		23c. NAME OF CEMETERY OR CREMATORY UNITED HEBREW CEM. HOLETHORPE, MD.			23d. LOCATION (City, town or county) (State)				
24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217 9th St NW WASH DC		25a. REC'D BY REGISTRAR FEB 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02633

CERTIFICATE OF DEATH

02600

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1 d. STREET ADDRESS <u>5945 LeMay Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George A. Upman</u>		4. DATE OF DEATH Month Day Year <u>Feb 14 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 14 1900</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ARTIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Atomic Energy</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Agustus A. Upman</u>		14. MOTHER'S MAIDEN NAME <u>Bessie MacKeehan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-50-2472</u>	
17. INFORMANT Address <u>Carol Miller - daughter -</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 CARDIAC ARREST</u> DUE TO (b) <u>ACUTE CORONARY OCCLUSION</u> DUE TO (c) <u>ARTERIO SCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 mins - 1 day - 20 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of prostate; cerebrovascular occlusion 2 weeks prior to death.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 28</u> , 1966, to <u>FEB. 12</u> , 1966, that (I) (we) last saw the deceased alive on <u>FEB. 12</u> , 1966, and that death occurred at <u>8:45 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Joseph P. Connor, M.D.</u>		22b. DATE SIGNED <u>FEB. 14, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH P. CONNOR, M.D.</u>		22d. ADDRESS <u>9420 Old Georgetown Rd Bethesda</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Great Valley Presby.</u>		23d. LOCATION (City or Town) (County) (State) <u>Chester County, Pa.</u>	
24. FUNERAL DIRECTOR <u>Ilyson Wheeler</u> ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

000350

000350

UNITED STATES DEPARTMENT OF THE ARMY	
OFFICE OF THE CHIEF OF STAFF	
WASHINGTON, D. C.	
1. NAME OF THE OFFICER	
2. GRADE	
3. BRANCH	
4. TITLE	
5. ADDRESS	
6. CITY	
7. STATE	
8. ZIP CODE	
9. PHONE NUMBER	
10. FAX NUMBER	
11. E-MAIL ADDRESS	
12. OTHER INFORMATION	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

-FOR STATE HEALTH DEPT

02634

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02601

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>7yr.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5920 Rudyard Dr.</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15-1</u>			
f. STREET ADDRESS <u>5920 Rudyard Dr.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alfred</u> First <u>Alfred</u> Middle <u>Valentino</u> Last <u>Valentino</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 12, 1921</u>	
9. AGE (In years lost birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Rail's</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Albert Valentino</u>				14. MOTHER'S MAIDEN NAME <u>Mary Berardis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>W.W.II</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Wife - Mary - Bethesda, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot - Wound of Head -</u> <u>976 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot - Self with 12 gauge shot gun with muzzle in mouth.</u>			
20c. TIME OF INJURY Month, Day, Year <u>2:00 p.m. 2/20 1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Mont.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.				22. DATE SIGNED <u>2/20/66</u>			
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u></u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/24/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem. Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State) <u></u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md.</u>				25. REC'D BY REGISTRAR <u>FEB 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

ru3Sg

35380

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02635 CERTIFICATE OF DEATH 02602

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lakewood Park</u> c. LENGTH OF STAY IN 1b <u>21 days</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>8500 Adelphi Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Wm</u> Last <u>Viands</u>		4. DATE OF DEATH Month <u>2</u> Day <u>-14</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-81</u> yrs. <u>84</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance</u>		11. BIRTHPLACE (County & State, or foreign country) <u>?</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>UNKNOWN</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Hospital Records</u> Address <u>?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>586X Congestive heart failure & atherosclerosis</u> DUE TO (b) <u>As gall bladder disease & overindulgence</u> DUE TO (c) <u>and perhaps dehydration & perforated ulcer</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>Autopsy</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15/66</u> , to <u>2/14/66</u> , that (I) (we) last saw the deceased alive on <u>2/13/66</u> , and that death occurred at <u>8/15/66</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Chas H Wolohin</u>		22b. DATE SIGNED <u>2/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolohin</u>		22d. ADDRESS <u>7600 Carroll Ave. Ink Pr. Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ROSEDALE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>MARTINSBURG, WEST VIRGINIA</u>	
24. FUNERAL DIRECTOR <u>J. Arthur Walters, 254 Carroll St. W 4c</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03030

03030

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page. The text is mostly centered and spans most of the page width.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02636

CERTIFICATE OF DEATH

02603

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8821 Flower Avenue</i>		d. STREET ADDRESS <i>8821 Flower Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Perry. Viands</i>		4. DATE OF DEATH Month <i>2</i> Day <i>2</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 3 1903</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired salesman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Salmon Used Cars</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>W Va</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
13. FATHER'S NAME <i>Charles Viands</i>		14. MOTHER'S MAIDEN NAME <i>Ella Schultz</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>577-05-523</i>	
17. INFORMANT <i>Mrs M Viands</i>		Address <i>8821 Flower Ave Silver Spring MD</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260X</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Occlusion</i> (c) <i>Debutus Sullitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7/4 hrs</i> <i>12/29/65</i> <i>11 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Myocarditis with Hypertension & Angina</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>4/11/1955</i> to <i>2/21/1966</i> , that (I) (we) lost the deceased alive on <i>1/23/1966</i> , and that death occurred at <i>4:30 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Howard T Morse</i>		22b. DATE SIGNED <i>2/2/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Howard T Morse</i>		22d. ADDRESS <i>7030 Gravel Ave Takoma Park</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-5-66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i>
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
4834 Georgia Avenue Silver Spring, Md.		DATE <i>FEB 7 1966</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

050013

UNITED STATES OF AMERICA

050013

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HONOLULU, HAWAII

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 21 Film G374 3/18/66									
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02637 CERTIFICATE OF DEATH 02604									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN b 15 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Clinical Center, Bethesda 14, Md.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY Nutley c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 67-3 d. STREET ADDRESS 275 Harrison Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Toni Ann Vitale			4. DATE OF DEATH February 18, 19 66						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 17 March 1957		9. AGE (In years last birthday) 8 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) New Jersey			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Anthony Vitale					14. MOTHER'S MAIDEN NAME Angelina Perrone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT The Medical Record The Clinical Center, Bethesda 14, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 7545 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Open Heart Surgery DUE TO (c) Congenital Heart Disease									INTERVAL BETWEEN ONSET AND DEATH 4 hours 24 hours 8 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from February 15, 19 66 , to February 15, 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 15, 19 66 , and that death occurred at 1:30 P. from the causes and on the date stated above.									
22a. SIGNATURE Scott Stewart					22b. DATE SIGNED 18 February 1966				
22c. PHYSICIAN'S NAME (Type) Scott Stewart, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda 14, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial-transit 2-19-66		Glendale Cemetery		Bloomfield, New Jersey					
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY ADDRESS Bethesda, Maryland					25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge		

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02538

02605

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA	
c. LENGTH OF STAY IN 1b D.O.A.		d. STREET ADDRESS 5715 HUNTINGTON PARKWAY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES S. von FREMD		4. DATE OF DEATH FEB. 25 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 7, 1925
9. AGE (In years lost birthday) 40 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CBS NEWS CORRESPONDENT	11. BIRTHPLACE (County & State, or foreign country) NEW YORK	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME CHARLES A. VON FREMD		14. MOTHER'S MAIDEN NAME ANTOINETTE FAILE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES 1945-46		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT VIRGINIA VON FREMD * WIFE		Address SAME as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infant, myocardial, recent DUE TO (b) Arteriosclerosis, coronary DUE TO (c) Anteroseptal, coronary			INTERVAL BETWEEN ONSET AND DEATH 2 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 8, 1962 , to Feb 25, 1966 , that (I) (we) lost saw the deceased alive on Feb 18, 1966 , and that death occurred at 9:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Charles Savarese Jr. M.D.		22b. DATE SIGNED 2-26-66	
22c. PHYSICIAN'S NAME (Type) CHARLES J. SAVARESE, Jr.		22d. ADDRESS 11125 Rockville Pike, Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 3-1-66	23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 2 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

15507

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

FOR STATE
HEALTH DEPT.

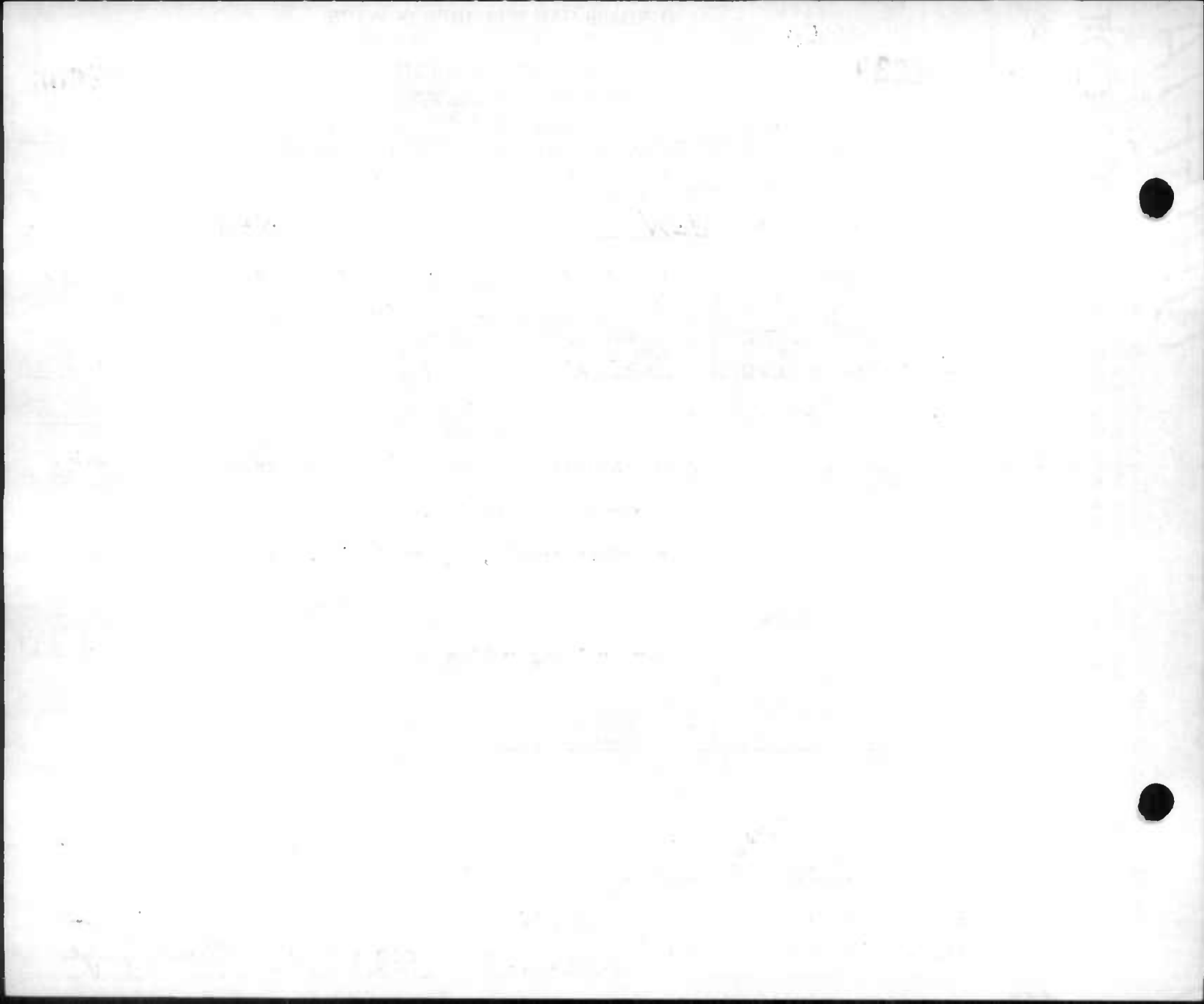
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02639

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02606

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>Years</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7827 Hampton Lane</u>				d. STREET ADDRESS <u>7827 Hampton Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Murrill</u> Last <u>Voss</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>4/18/1898</u>		9. AGE (In years lost birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising Mng.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Stores</u>		11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis, John. Voss</u>				14. MOTHER'S MAIDEN NAME <u>MATHILDE KULL</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>521-03-4012</u>		17. INFORMANT <u>Son - Edwin P. Voss - same item #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Myocardial Infarction, Recent and remote</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized severe</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pt Cerebral Infarction</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) <u>Pt Cerebral Infarction</u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u>		EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/8/66</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>2-8-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill CREMATORY</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Son's Inc.</u>				25a. RECEIVED BY REGISTRAR <u>WASK. & C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 11 1966</u>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02640

02607

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R. Rockville</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11701 Ibson Rd.</u>				d. STREET ADDRESS <u>11701 Ibson Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Lester</u> Last <u>Walker</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 17, 1914</u>	
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director Man. Personnel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>GOV.</u>		11. BIRTHPLACE (State or foreign country) <u>Montana</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Oliver Walker</u>				14. MOTHER'S MAIDEN NAME <u>Alice Webber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or defense service) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>390-07-7426</u>		17. INFORMANT Address <u>Eva Hitch Walker, Wife</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia by Hanging</u> 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung Self by Rope in Basement of home</u>			
20c. TIME OF INJURY Month, Day, Year <u>6</u> hour <u>a.m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Rockville Mont-Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>				22. DATE SIGNED <u>2/11/66</u>			
EXAMINER'S NAME (Type) JOHN G. BALL 7936 Old Georgetown Rd. Bethesda, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u> </u>		23b. DATE THEREOF <u>2-11-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR TYSON WHEELER 1331 Rockville Pike Rockville, Maryland				25a. REC'D BY REGISTRAR DATE <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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UNITED STATES DEPARTMENT OF AGRICULTURE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02608

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 10 yr.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6033 Avon Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VIOLA Middle MAE Last (KELLER) WALKER				4. DATE OF DEATH Month Feb Day 1 Year 1966			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 16, 1883	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Public Utilities		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis Keller				14. MOTHER'S MAIDEN NAME Mollie Marie Roth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-44-4532		17. INFORMANT Henryetta Walker Eaton Address 6033 Avon Drive Bethesda, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic heart failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive heart disease DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH weeks years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large abdominal aneurysm.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1956 to Jan 31, 1966 , that (I) (we) last saw the deceased alive on Jan 31, 1966 , and that death occurred on Feb 1, 1966 from the causes and on the date stated above.							
22a. SIGNATURE C. P. Ryland				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20016	
22c. PHYSICIAN'S NAME (Type) C P RYLAND				22d. ADDRESS 4400-49th St. Washington DC 21-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 2/1 /66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City, town, or county) (State) Prince George Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				ADDRESS 1331 Rockville Pike Rockville, Maryland		25a. REC'D BY REGISTRAR FEB 4 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02642

02609

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>47 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shut Hyattsville</u> 16-2 d. STREET ADDRESS <u>5902 31st Ave Apt. 316</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Walter Walker</u>			4. DATE OF DEATH Month Day Year <u>2 15 1966</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/10/14</u>		9. AGE (In years last birthday) <u>52</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 Hrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Walker Distribution</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delicatessen Products</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dynwre, PA.</u>			
13. FATHER'S NAME <u>Walekiewicz</u>			14. MOTHER'S MAIDEN NAME <u>Fances Stefanowicz</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1944-46</u>		16. SOCIAL SECURITY NO. <u>2 15 10 7455</u>		17. INFORMANT Address <u>1617 N. Carroll</u> <u>Staller Stefanowicz</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive gastro-intestinal hemorrhage</u> DUE TO (b) <u>Ruptured esophageal varices</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Laennec's cirrhosis of the liver</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5811</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) <u>(this informant)</u> attended the deceased from <u>Feb. 15</u> , 19 <u>66</u> , to <u>February 15</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Feb. 15</u> , 19 <u>66</u> , and that death occurred at <u>7:15 P.M.</u> from causes <u>and</u> on the date stated above.							
22a. SIGNATURE <u>J. Blaine Fitzgerald</u>			22b. DATE SIGNED <u>2/15/66</u>		22c. PHYSICIAN'S NAME (Type) <u>J. Blaine Fitzgerald</u>		
22d. ADDRESS <u>8218 Wisconsin Avenue Bethesda</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				
23b. DATE THEREOF <u>Feb 18, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery, Arlington, Virginia</u>		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <u>Clonk & Alvin Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>FEB 23 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STANDARD PAPER CO.

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STANDARD PAPER CO.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02643

CERTIFICATE OF DEATH

02610

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b 18 months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Potomac Valley Nursing Home			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda d. STREET ADDRESS 5632 Bradley Blvd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Ora Middle Ann Last Ward			4. DATE OF DEATH Month February Day 23 Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1869		9. AGE (In years lost birthday) 96 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Oren Hook			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -			16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. John L DeMayo, 5632 Bradley Blvd Bethesda, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500x Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute Tracheobronchitis DUE TO (c) -					INTERVAL BETWEEN ONSET AND DEATH 2 hours 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb 18 , 19 66 , to Feb 23 , 19 66 , that (I) (we) last saw the deceased alive on Feb 22 , 19 66 , and that death occurred at 9:35 AM , from causes and on the date stated above.					
22a. SIGNATURE Clifton R Gruyer			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2/23/66
22c. PHYSICIAN'S NAME (Type) Clifton R. GRUYER			22d. ADDRESS 915 19th St NW Wash DC		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-25-1966	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION (City or Town) (County) (State) Washington, D. C.	
24. FUNERAL DIRECTOR Jos. Hawley's Sons Inc.			25. RECEIVED BY REGISTRAR Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 5-63

UNITED STATES DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02644

02611

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>35 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM + HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> <u>16-2</u> d. STREET ADDRESS <u>7200 TRESPOTT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>RILLA ELIZABETH WAYLAND</u>			4. DATE OF DEATH <u>FEBRUARY 4 1966</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 30, 1908</u>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Govt</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WISCONSIN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>CHARLES HOFFMIRE</u>		
14. MOTHER'S MAIDEN NAME <u>EMMA ROBERTS</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>HOSPITAL RECORDS</u>			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Innervation & malnutrition</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinomatosis - intraabdominal</u> (c) <u>Adenocarcinoma of the ovary</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <u>Jan 1, 1966</u> to <u>Feb 4, 1966</u> that (1) (we) last saw the deceased alive on <u>Feb 4, 1966</u> and that death occurred at <u>3:58 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilfred W Eastman</u>			22b. DATE SIGNED <u>Feb 4, 1966</u>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB. 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEM.</u>	
23d. LOCATION (City, town or county) <u>SUITLAND, MARYLAND</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>LEE FUNERAL HOME</u>			
25a. REC'D BY REGISTRAR <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1050

1050

RECEIVED
FEB 10 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02645

CERTIFICATE OF DEATH

02612

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8502-16th ST.</u>		d. STREET ADDRESS <u>8502-16th ST.</u>	
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>Weinberg</u> Last <u>Weinberg</u>		4. DATE OF DEATH <u>Feb. 5</u> 19 <u>66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1883</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Rosenfeld</u>		14. MOTHER'S MAIDEN NAME <u>Bayla</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Joseph H. Weinberg - Potomac, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> <u>4201</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 men</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 1955</u> , 19 <u> </u> , to <u>Feb 5</u> , 19 <u>66</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Feb 4</u> , 19 <u>66</u> , and that death occurred at <u>12:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Simon C. Weiner</u>		22b. DATE SIGNED <u>Feb 5, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>SIMON C. Weiner</u>		22d. ADDRESS <u>8201-16th ST. Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb 6, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Hyattsville, Md.</u>
24. FUNERAL DIRECTOR <u>B. Dargansky Sons 3301-14th St NW Wash DC</u>		25a. REC'D BY REGISTRAR <u>Feb 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05012

05012

VR A15 (4)
20M 1/65

1. PLACE OF DEATH a. COUNTY MONTGOMERY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Howard							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 4 months 15 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) D Laurel				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fairland Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Alice X Whittaker						4. DATE OF DEATH Month Day Year 2 - 5 1966							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-31- 75 91		9. AGE (In years last birthday) yrs. 91		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.				12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME William D Burton						14. MOTHER'S MAIDEN NAME Mary Edy Jackson							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. [blank]		17. INFORMANT John Whittaker		Address Laurel Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen arteriosclerosis DUE TO (c) Hypertension										INTERVAL BETWEEN ONSET AND DEATH 3 day			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Bronchitis, Asthma													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2/3 , 19 66 , to 2/5 , 19 66 , that (I) (we) last saw the deceased alive on 3/5 19 66 , and that death occurred at 6:10 PM , from the causes and on the date stated above.													
22a. SIGNATURE B.P. Warren						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) B.P. WARREN						22d. ADDRESS Laurel Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-8-66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.				23d. LOCATION (City, town or county) (State) Calmar Manor Md.					
24. FUNERAL DIRECTOR Robert Burman						ADDRESS Laurel Md.		25a. REC'D BY REGISTRAR FEB 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

10551

03030

(1)

MEDICAL CERTIFICATION

VR A15 (4)
20 M 1/66

\$1250

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02615

02648

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D. C.</u> b. COUNTY <u>Washington, D. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>	
c. LENGTH OF STAY IN 1b <u>2 months</u>		47-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3912 Joliet Street</u>		d. STREET ADDRESS <u>6316 2nd Street, N. W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>Helen</u> Last <u>Wolfe</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1893</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telephone operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>Wichle, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas A. Coulter</u>		14. MOTHER'S MAIDEN NAME <u>Emma J. Bradford</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>578-32-5689</u>	
17. INFORMANT <u>Mrs. E. Lucille Bancroft</u>		Address <u>1832 Metzert Rd. Adelphi, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>3 YEARS</u> <u>15 YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> , 1953, to <u>FEB 10</u> , 1966, that I last saw the deceased alive on <u>FEB 8</u> , 1966, and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert L. Krichmar</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>7733 ALASKA AVENUE NW FEB 10 1966</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT L. KRICHMAR</u>		<u>WASHINGTON DC 2002</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02649

02616

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> , MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>1643 East Jefferson St</u>			
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Wood</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>11</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 9, 1966</u>	
9. AGE (In years last birthday) <u>-</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u> Hours <u>-</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>			
13. FATHER'S NAME <u>Richard Cameron Wood</u>				14. MOTHER'S MAIDEN NAME <u>Mary Penelope Mc Mahon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records.</u> <u>Birth Certificate</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Aelectrosis</u> <u>7625</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-9</u> , 19 <u>66</u> , to <u>2-11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-11</u> , 19 <u>66</u> , and that death occurred at <u>3:59</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Francis J. Troendle</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-12-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS J. TROENDLE</u>				22d. ADDRESS <u>50 W. Edmonston Dr. Rockville</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>2-12-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Southampton, New York</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey Bethesda, Md.</u>				25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

6-168473

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
02650 Montgomery Co.						02617					
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring Maryland</u>				c. LENGTH OF STAY IN 1b <u>8 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chevy Chase Nursing & Convalescent Center</u>						d. STREET ADDRESS <u>5932 9th St. N.W.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fannie</u> Middle <u>Woronow</u> Last <u>Woronow</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>14</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 14 1879</u>		9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shopsin HELLER</u>						14. MOTHER'S MAIDEN NAME <u>Hertweide Heller</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ALBERT W. WORONOW</u> Address <u>6001 MARQUETTE RD. BETHESDA, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>10 years</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Multiple repeated cerebral thromboses.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <u>0</u> a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 13</u> , 19 <u>65</u> , to <u>Feb 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 3</u> , 19 <u>66</u> , and that death occurred at <u>3 P.</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>A.J. Connolly</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 6, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>A.J. CONNOLLY</u>						22d. ADDRESS <u>1635 IRVING ST. N.W. WASHINGTON, D.C.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ADAS ISRAEL CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>WASH. DC</u>					
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u>						25a. REC'D BY REGISTRAR DATE <u>FEB 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

05815

RECEIVED 20 JAN 1970

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02651

CERTIFICATE OF DEATH

02618

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) POTOMAC d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 9119 MARSEILLE DR.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WASHINGTON D.C. b. COUNTY WASHINGTON D.C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47-3 d. STREET ADDRESS 3138 MILITARY RD., N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MYRTLE DOROTHY WYATT	4. DATE OF DEATH FEB. 2 1966	5. SEX F	
6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 27, 1898	9. AGE (in years last birthday) 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) PLEDGER, TEXAS	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME MARK WILLIAMS	14. MOTHER'S MAIDEN NAME JOYCE BESS		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Rectal Bleeding of Undetermined Cause 5781 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) QUE TO (c) QUE TO			INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Advanced Breast Carcinoma with Metastasis to Spine + Lungs			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 29, 1966 , to Jan 29, 1966 , that (I) (we) last saw the deceased alive on Jan. 29 1966 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE William R. Hyde	M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-7-66	
22c. PHYSICIAN'S NAME (Type) Robert L. Snowden	22d. ADDRESS 3326 Ga. Ave. N.W.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Transit	23b. DATE THEREOF 2/8/66	23c. NAME OF CEMETERY OR CREMATORY Rockville, Md.	23d. LOCATION (City, town or county) (State) Bay City, Texas
24. FUNERAL DIRECTOR Robert L. Snowden	25a. REC'D BY REGISTRAR FEB 14 1966		
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

05012

05012

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Items 8, 9 Film G377 5/31/66 mh											
1. PLACE OF DEATH e. COUNTY Montgomery						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Silver Spring					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington, D. C.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Althea Woodland Nursing Home						d. STREET ADDRESS 3517 - 16th Street N. W.					
3. NAME OF DECEASED (Type or print) Marjorie S. Wyman						4. DATE OF DEATH Month February Day 25 Year 19 66					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/12/96 1895		9. AGE (In years last birthday) yrs. 70 69		IF UNDER 1 YEAR Months 25 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY Ohio				11. BIRTHPLACE (County & State, or foreign country) U. S. A.			
13. FATHER'S NAME Rolla W. Saunders						14. MOTHER'S MAIDEN NAME Nellie Jane Drake					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. no		17. INFORMANT Nursing Home Records - same as #1				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) Osteoarthritis, generalized DUE TO (c) Gen'l. arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1955 , 19....., to 2/25 , 19 66 , that (I) (we) last saw the deceased alive on 2/25/66 19....., and that death occurred at 2 P. M., from the causes and on the date stated above.											
22a. SIGNATURE John E. Everett						M.D. JOHN E. EVERETT		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) JOHN E. EVERETT						22d. ADDRESS 9400 Conn. Av. Kensington Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2/28/66		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Prince Georges Co. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Company-Washington, D.C.						ADDRESS Washington, D.C.		25. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02653 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>						c. LENGTH OF STAY IN 1b <u>10 days 23 hrs 36 min</u>							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>						16-2							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San & Hosp</u>						d. STREET ADDRESS <u>6804 20th Ave</u>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>VIRGINIA MARY VARNEU</u>						4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1966</u>							
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>8-25-93</u>							
9. AGE (In years last birthday) <u>72</u> yrs.						IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>							
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Whalen</u>						14. MOTHER'S MAIDEN NAME <u>Elizabeth McGuire</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>—</u>							
17. INFORMANT <u>Archibald S. Yarnell</u>						Address <u>as above</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>1561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of liver</u> DUE TO (c) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> , 19 <u>60</u> , to <u>Feb 17</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 17</u> , 19 <u>66</u> , and that death occurred at <u>5:10 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Robert B. Irey</u>						22b. DATE SIGNED <u>2-18-66</u>							
22c. PHYSICIAN'S NAME (Type) <u>ROBERT B. IREY</u>						22d. ADDRESS <u>7105 Riggs Rd. Hyattsville, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)							
<u>Burial</u>		<u>2-23-66</u>		<u>Arlington National Cem.</u>		<u>Arlington Va.</u>							
24. FUNERAL DIRECTOR <u>Francis J. Gallin</u>						ADDRESS <u>3821-14th NW, Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

105230

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[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

Approved by Mr. Reap

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02654 CERTIFICATE OF DEATH 02621											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15-1 d. STREET ADDRESS <u>1612 FLORA LANE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First Middle Last			4. DATE OF DEATH <u>2-2-1966</u> Month Day Year		9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-19</u>		11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL LIQ. STORE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LIQUOR</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>SADORE ZALEZNIK</u>					14. MOTHER'S MAIDEN NAME <u>ANNA</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>186-09-5477</u>		17. INFORMANT <u>SOPHIA ZALEZNIK</u> (Same as 20b) Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> 4201 DUE TO (b) <u>Chr. coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>12 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>65</u> , to <u>Feb 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 19 <u>66</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Simon C. Weiner</u> 22c. PHYSICIAN'S NAME (Type) <u>SIMON C. WEINER</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 2, 1966</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. REBABON CEM</u>		23d. LOCATION (City, town or county) (State) <u>HYATTSVILLE, MD.</u>				
24. FUNERAL DIRECTOR <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St NW</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE				
DATE <u>FEB 7 1966</u>											

